

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12392

12407

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Nr. Westminster</b>				c. LENGTH OF STAY IN 1b <b>18 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Westminster, Md. R. D. 2</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First <b>Calvin</b> Middle <b>M.</b> Last <b>Albers</b>				4. DATE OF DEATH Month <b>11/13/59</b> Day <b>19</b> Year <b>19</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/28/1894</b>	
9. AGE (In years last birthday) <b>65</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		11. BIRTHPLACE (State or foreign country) <b>Cambridge, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ezra Albers</b>				14. MOTHER'S MAIDEN NAME <b>Rosa Mills</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-12-2862</b>		17. INFORMANT <b>Mrs. Calvin M. Albers, Westminster, Md. R.D.2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary thrombosis</b> (c) <b>Valvular Heart Disease</b>				INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>1 month</b> <b>3 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Sept 15, 1959</b> , to <b>Nov 13, 1959</b> , that I last saw the deceased alive on <b>Nov 13, 1959</b> , and that death occurred at <b>10:05 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Julius Chepko</b>				ADDRESS (Street, city or town, state) <b>851 W. Green Westminster Md</b>			
PHYSICIAN'S NAME (Type) <b>Richard A. Little</b>				DATE SIGNED <b>11/13/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/16/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Grave Run Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co., Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard A. Little</b>				ADDRESS <b>Littlestown, Pa.</b>		24a. REC'D BY REGISTRAR <b>NOV 16 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kline</b>							



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12393
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										12408
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>			c. LENGTH OF STAY IN 1b <b>34 yrs. 5 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			3401-4		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>					d. STREET ADDRESS <b>2533 Pennsylvania Ave.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Amend</b> Last <b>Amend</b>					4. DATE OF DEATH Month <b>November</b> Day <b>23</b> Year <b>1959</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 22, 1898</b>		9. AGE (In years last birthday) <b>61</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>George L. Amend</b>					14. MOTHER'S MAIDEN NAME <b>Mary Cecilia Gilmore</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fracture, neck right femur</b> DUE TO (c) <b>-</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Epilepsy with mental deficiency.</b>										INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>18 days</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell to floor</b>							
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>11/5/ 19 59</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		20f. (City or town) <b>Sykesville Carroll</b>		(County) <b>Md.</b>		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <b>James T. Marsh</b>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED
EXAMINER'S NAME (Type) <b>James T. Marsh, M.D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					<b>11/23/59</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/25/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's</b>			22d. LOCATION (City, town, or county) <b>Balto. Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank Della Voce</b>					24a. REC'D BY REGISTRAR DATE <b>NOV 27 '59</b>		24b. REGISTRAR'S SIGNATURE <b>James L. Marsh</b>			



TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12394

12409

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>8 yrs. 11 da.</b>		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 5, Maryland</b>		3V01-4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>811 N. Bradford Street</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Louis</b> Middle <b>Herman</b> Last <b>Appel</b>		4. DATE OF DEATH Month <b>November</b> Day <b>25</b> Year <b>19 59</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 12, 1867</b>	
9. AGE (In years last birthday) <b>92</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Edward Appel</b>		14. MOTHER'S MAIDEN NAME <b>Mary Hamel</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>		
INFORMANT <b>Springfield State Hospital Records</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH <b>days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile psychosis, simple deterioration</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>May 9, 19 58</b> , to <b>November 25, 19 59</b> , that I last saw the deceased alive on <b>November 25, 19 59</b> , and that death occurred at <b>12:45 A.M.</b> from the causes and on the date stated above.				
ACTUAL SIGNATURE <b>Agustini del Campo</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>		DATE SIGNED <b>11/25/59</b>
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M. D.</b>		<b>Sykesville, Maryland</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 28/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt/ Carmel Cem/</b>
22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Philip Herwig Sons</b>		ADDRESS <b>2024 Orleans St</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 30 '59</b>
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>				

CERTIFICATE OF DEATH

NEW YORK

County of New York

City of New York

State of New York

Year 1901

Month of

Day of

At New York, New York

I, the undersigned

being a duly qualified

physician, do hereby

certify that the

above named person

came to his or her

end at New York

at the age of

years

months

days

and that the

cause of death

was



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12410

## CERTIFICATE OF DEATH

12395

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Life</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LOUIS LEE ARMSWORTHY</u> First Middle Last		4. DATE OF DEATH <u>Nov. 24</u> 19 <u>59</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 30, 1882</u> 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Springfield Hospital</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>? - Armsworthy</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>unk</u>	
17. INFORMANT <u>Mrs Mary A. Armsworthy - wife</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> (c) <u>Hypertension.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours.</u> <u>years.</u> <u>years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11. 24</u> , 19 <u>59</u> , to <u>11. 24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11. 24</u> , 19 <u>59</u> , and that death occurred at <u>6:35</u> PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>37 Central Ave. Sykesville, Md.</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Sani Okutman</u> M.D.		PHYSICIAN'S NAME (Type) <u>A. Sani Okutman</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-27-59</u>	
22c. NAME OF CEMETERY OR CREMATOR <u>Springfield</u>		22d. LOCATION (City, town, or county) (State) <u>Sykesville, Carroll, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u> ADDRESS <u>Sykesville, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 30 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haight</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Uniontown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Uniontown, Md.</u>	
c. LENGTH OF STAY IN 1b <u>3 yrs.</u>		d. STREET ADDRESS <u>Uniontown Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Louise</u> Last <u>Berkemeier</u>		4. DATE OF DEATH Month <u>November</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 27, 1880</u>
9. AGE (In years lost birthday) yrs. <u>79</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Schlegel</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mr. Calvin C. Berkemeier, Uniontown Rd.</u>		Address <u>Uniontown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio-Vascular Disease; years.</u> 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/11/59</u> , 19 <u>59</u> , to <u>11/29/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/29/59</u> , 19 <u>59</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. E. Robertson</u> M.D.		ADDRESS (Street, city or town, state) <u>New Windsor, Md.</u> DATE SIGNED <u>11/29/59</u>	
PHYSICIAN'S NAME (Type) <u>M. E. Robertson, M.D.</u>		<u>New Windsor, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 2, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Pikesville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 3 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED

NOTED IN

MAINTAINED

Blank form with horizontal lines for text entry.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12397

12412

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>12 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>(Dortch)</b> Last <b>Bortch</b>				4. DATE OF DEATH Month <b>11</b> Day <b>7</b> Year <b>19 59</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/9/18</b>		9. AGE (In years last birthday) <b>41</b> yrs.	IF UNDER 1 YEAR Months <b>11</b> Days <b>7</b> Hours <b>19</b> Min.	IF UNDER 24 HRS. Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Max Dortch</b>			14. MOTHER'S MAIDEN NAME <b>Jenny Tublan</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO. <b>219-38-2618</b>		INFORMANT Address <b>Records Springfield Hosp. Sykesville, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause last. (b) <b>Uremia due to subacute glomerulonephritis</b> DUE TO (c) <b>Primary behavior disorder; conduct disturbance.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11/2/59</b> , 19 <b>59</b> , to <b>11/7/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11/7/59</b> , 19 <b>59</b> , and that death occurred at <b>3:55 a.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield Hospital, Sykesville, Md.</b> DATE SIGNED <b>11/7/59</b>							
ACTUAL SIGNATURE <b>Francesco Magro</b>			M.D. <b>Springfield Hospital, Sykesville, Md.</b>				
PHYSICIAN'S NAME (Type) <b>Francesco Magro, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 9-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Not known</b>		22d. LOCATION (City, town, or county) (State) <b>Bald. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis Inc. - 2100 Eastern Place</b>				24a. REC'D BY REGISTRAR <b>NOV 10 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

## 42

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Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12413

## CERTIFICATE OF DEATH

Reg. Dist. No.

12398

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>33 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>4 Chestnut Hill Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Nellie</b> Middle <b>N.</b> Last <b>Boughner</b>		4. DATE OF DEATH Month <b>November</b> Day <b>2,</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 16, 1881</b>
9. AGE (In years lost birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Daniel Boughner</b>		14. MOTHER'S MAIDEN NAME <b>Mary N. Nicholson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far advanced bilateral pulmonary tuberculosis</b> 002x DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, paranoid type.</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 7,</b> 19 <b>55</b> , to <b>November 2,</b> 19 <b>59</b> , that I last saw the deceased alive on <b>November 2,</b> 19 <b>59</b> , and that death occurred at <b>1:15 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>11/2/59</b>			
ACTUAL SIGNATURE <b>Agustin del Campo</b>		M.D. <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>11/5/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.-2901 14th St., N.W.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 4 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			





TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12414

CERTIFICATE OF DEATH

Reg. Dist. No.

12399

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>3yrs. 7mths.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Celestenia Serena Brady</b>		4. DATE OF DEATH Month Day Year <b>Nov. 28 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-1-72</b>
9. AGE (In years last birthday) <b>87</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Felix Salter</b>		14. MOTHER'S MAIDEN NAME <b>Martha Crippen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT Address <b>Mrs. Florence Benson, 6103 Walhonding Rd. Glen Echo Heights, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b> days 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Arterio Sclerotic Heart Disease</b> months (c) <b>General Arteriosclerosis</b> years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/25</b> , 19 <b>59</b> , to <b>11/28</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11/28</b> , 19 <b>59</b> , and that death occurred at <b>12:30 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Francesco Magro</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hosp.</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Francesco Magro</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/2/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY INC. SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 1 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			

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2

CERTIFICATE OF DEATH

STATE OF NEW YORK

County of \_\_\_\_\_

City of \_\_\_\_\_

Town of \_\_\_\_\_

Ward of \_\_\_\_\_

Block of \_\_\_\_\_

Lot of \_\_\_\_\_

Section of \_\_\_\_\_

Subdivision of \_\_\_\_\_

Tract of \_\_\_\_\_

Parcel of \_\_\_\_\_

Part of \_\_\_\_\_

Whole of \_\_\_\_\_

Other \_\_\_\_\_

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

12460

12415

1. PLACE OF DEATH o. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sylkesville</i>	c. LENGTH OF STAY IN 1b <i>17 yrs.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sylkesville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>31 Central Ave.</i>		d. STREET ADDRESS <i>1 31 Central Ave.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Minnie</i> Middle <i>-</i> Last <i>Brown</i>		4. DATE OF DEATH Month <i>11</i> Day <i>13</i> Year <i>1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 28 1872</i>
9. AGE (In years last birthday) <i>87</i> yn.		IF UNDER 1 YEAR Months <i>21</i> Days <i>21</i> Hours <i>21</i> Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Samuel Hobbs</i>	
14. MOTHER'S MAIDEN NAME <i>Mary Elan Doyle</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Oscar L. Hawkins</i> Address <i>Sylkesville</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertension, Arteriosclerosis</i> DUE TO (c) <i>Cardiovascular Disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>4 months</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cachexia, Dehydration</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>7-9-59</i> to <i>11-13-59</i> , that I last saw the deceased alive on <i>11-13-59</i> , and that death occurred at <i>6:00 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Sani Okutman</i> M.D.		ADDRESS (Street, city or town, state) <i>37 Central Ave Sylkesville Md.</i> DATE SIGNED <i>Nov 14 59</i>	
PHYSICIAN'S NAME (Type) <i>Sani A. Okutman</i>		<i>Sylkesville Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>11-15-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Springfield</i>	22d. LOCATION (City, town, or county) (State) <i>Sylkesville, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Haugh</i>		ADDRESS <i>Sylkesville, Md.</i>	
24a. REC'D BY REGISTRAR DATE <i>NOV 18 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur H. Haugh</i>	

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12401

12415

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>15yrs.8mos.17days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>None</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Helena</u> Middle <u>Frances</u> Last <u>Bucholtz</u>				4. DATE OF DEATH Month <u>November</u> Day <u>19</u> , Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 23, 1921</u>	
9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Stickley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Springfield Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral aspiration bronchopneumonia</u> DUE TO (b) <u>(Final diagnosis to be determined by toxicological studies.)</u> DUE TO (c) <u>Psychoneurotic disorder, anxiety reaction.</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Psychoneurotic disorder, anxiety reaction.</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James T. Marsh</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James T. Marsh, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <u>11/20/59</u>							
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-22-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Freedom</u>		22d. LOCATION (City, town, or county) (State) <u>Liberty Rd. Sykesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Haight</u>				ADDRESS <u>Sykesville, Md.</u>			
24a. REC'D BY REGISTRAR <u>Nov 25 '59</u>				24b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Phone <sup>St</sup> and Exam.

no report 2/2/68  
as.

109 E. Main St  
Westwood

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12417

## CERTIFICATE OF DEATH

12402

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mariettaville</u> 13X-2	
		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John William Burke</u>		4. DATE OF DEATH Month Day Year <u>November 8 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 31, 1901</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Burke</u>		14. MOTHER'S MAIDEN NAME <u>Annie C. Cutsail</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-09-1760</u>	
17. INFORMANT <u>William C. Burke</u> Address <u>Sykesville, Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis, Anterior</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>heart disease, Anterior</u> DUE TO (c) <u>myocardial infarction</u> INTERVAL BETWEEN ONSET AND DEATH <u>1958 to 8 Nov 59</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8 Nov 1959</u> to <u>8 Nov 59</u> , that I last saw the deceased alive on <u>8 Nov 1959</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.		ADDRESS (Street, city or town, state) <u>Sykesville, Md</u> DATE SIGNED <u>11-8-59</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>		<u>SYKESVILLE, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 11, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Providence Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick County, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>NOV 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William E. Hall</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2017

Section 10

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. RACE <i>White</i>	
5. PLACE OF BIRTH <i>New York, N.Y.</i>		6. DATE OF BIRTH <i>Jan 1, 1972</i>		7. TIME OF DEATH <i>10:15 AM</i>		8. PLACE OF DEATH <i>Home</i>	
9. CAUSE OF DEATH <i>Heart Disease</i>		10. MANNER OF DEATH <i>Natural</i>		11. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		12. SIGNATURE OF REGISTRAR <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>		16. SIGNATURE OF WITNESS <i>John Doe</i>	
17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>		19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	
21. SIGNATURE OF WITNESS <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF WITNESS <i>John Doe</i>		28. SIGNATURE OF WITNESS <i>John Doe</i>	
29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>		31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>	
33. SIGNATURE OF WITNESS <i>John Doe</i>		34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF WITNESS <i>John Doe</i>		40. SIGNATURE OF WITNESS <i>John Doe</i>	
41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>		43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>	
45. SIGNATURE OF WITNESS <i>John Doe</i>		46. SIGNATURE OF WITNESS <i>John Doe</i>		47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>		51. SIGNATURE OF WITNESS <i>John Doe</i>		52. SIGNATURE OF WITNESS <i>John Doe</i>	
53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>		55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>	
57. SIGNATURE OF WITNESS <i>John Doe</i>		58. SIGNATURE OF WITNESS <i>John Doe</i>		59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF WITNESS <i>John Doe</i>		64. SIGNATURE OF WITNESS <i>John Doe</i>	
65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>		67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>	
69. SIGNATURE OF WITNESS <i>John Doe</i>		70. SIGNATURE OF WITNESS <i>John Doe</i>		71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF WITNESS <i>John Doe</i>		76. SIGNATURE OF WITNESS <i>John Doe</i>	
77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>		79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>	
81. SIGNATURE OF WITNESS <i>John Doe</i>		82. SIGNATURE OF WITNESS <i>John Doe</i>		83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>		87. SIGNATURE OF WITNESS <i>John Doe</i>		88. SIGNATURE OF WITNESS <i>John Doe</i>	
89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>		91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>	
93. SIGNATURE OF WITNESS <i>John Doe</i>		94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF WITNESS <i>John Doe</i>		100. SIGNATURE OF WITNESS <i>John Doe</i>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12418

## CERTIFICATE OF DEATH

Reg. Dist. No.

12403

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural--Mt. Airy</b>		c. LENGTH OF STAY IN 1b <b>35 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Flag Marsh Road</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural-- Mt. Airy</b>	
3. NAME OF DECEASED (Type or print) First <b>ELSIE</b> Middle <b>THOMAS</b> Last <b>DAVIS</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>6</b> Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>12-17-1894</b>
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John E. Davis</b>		14. MOTHER'S MAIDEN NAME <b>Linda E. Hatfield</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mr. August E. Davis,</b>		Address <b>same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of stomach and</b> <b>151X</b> DUE TO <b>General Infection</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 4</b> , 19 <b>59</b> , to <b>Nov 6</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Nov 5</b> , 19 <b>59</b> , and that death occurred at <b>9:15 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>C M Van Pool</b> M.D. <b>Nov 6 1959</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>C M Van Pool</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11-9-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive</b>		22d. LOCATION (City, town, or county) (State) <b>Carroll Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b>		ADDRESS <b>Winfield, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>NOV 10 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Colbert E. Kraus</b>	



# CERTIFICATE OF DEATH

1912

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

THE STATE

NAME OF DECEASED John E. Davis		AGE 35		SEX Male		RACE White		DATE OF BIRTH 12-13-1876		PLACE OF BIRTH Maryland		U.S.	
RESIDENCE John E. Davis		MARRIAGE None		MOTHER Mrs. Ann E. Davis		FATHER Mr. John E. Davis		DATE OF DEATH 12-13-1912		PLACE OF DEATH Maryland		U.S.	
CAUSE OF DEATH Diphtheria		PERIOD OF ILLNESS 10 days		PLACE OF ILLNESS Home		NAME OF PHYSICIAN Dr. J. H. Smith		NAME OF NURSE Mrs. J. H. Smith		NAME OF BIRTH ATTENDANT None		NAME OF CORONER None	
SIGNATURE OF DECEASED None		SIGNATURE OF NEXT OF KIN None		SIGNATURE OF PHYSICIAN Dr. J. H. Smith		SIGNATURE OF NURSE Mrs. J. H. Smith		SIGNATURE OF BIRTH ATTENDANT None		SIGNATURE OF CORONER None		SIGNATURE OF WITNESSES None	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12420

## CERTIFICATE OF DEATH

12405

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>30yrs. 1mo. 16days</b> <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>3508 Forrest Hill Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary Winkler Emrine</b>		4. DATE OF DEATH Month Day Year <b>November 20, 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 29, 1892</b>
9. AGE (In years lost birthday) <b>67 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alvin Winkler</b>		14. MOTHER'S MAIDEN NAME <b>Walburga Tuchholl</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>-</b>	
INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Epilepsy with mental deficiency. Diabetes Mellitus.</b> INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 7, 1955</b> to <b>November 20, 19 59</b> that I last saw the deceased alive on <b>November 19, 1959</b> , and that death occurred at <b>12:45AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>11/20/59</b>			
ACTUAL SIGNATURE <b>Agustini del Campo</b>		M.D. <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11-23-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Geo. L. Schwab</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 23 '59</b>	
ADDRESS <b>Francis W. Galloway 2101 Frederick Ave. Balt. Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12406

12404

1. PLACE OF DEATH o. COUNTY <b>CARROLL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b>		c. LENGTH OF STAY IN 1b <b>years 27</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>74 RALPH ST</b>		d. STREET ADDRESS <b>74 Ralph St</b>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>L</b> Last <b>ENDERS</b>		4. DATE OF DEATH Month <b>Nov</b> Day <b>24</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 23, 1885</b>
9. AGE (In years last birthday) <b>74</b>		IF UNDER 1 YEAR: Months <b>74</b> Days <b>74</b> Hours <b>74</b> Min. <b>74</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ret'd Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Franklin Balmar Corporation</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-03-2754</b>	
17. INFORMANT <b>Marie J. Enders, Westminster, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>581.0 Embolism of the heart</b> DUE TO <b>AS.C.V. Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>AS.C.V. Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1956</b> to <b>11-24</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11-2</b> , 19 <b>59</b> , and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James J. Sharon</b> M.D.		ADDRESS (Street, city or town, state) <b>Westminster Md</b>	
PHYSICIAN'S NAME (Type) <b>JAMES T. MARSH</b>		DATE SIGNED <b>11-24-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11-27-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Memorial Garden</b>	22d. LOCATION (City, town, or county) (State) <b>Carroll County, Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR <b>NOV 25 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12407

12421

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Rural) Sykesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 13, 3V01-4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>H enry</u> Middle <u>Joseph</u> Last <u>Fleischman</u>				4. DATE OF DEATH Month <u>11</u> Day <u>4</u> Year <u>19 59</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-11-19 6/14/94</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u>05</u> Days <u>05</u> Hours <u>05</u> Min. <u>05</u>	IF UNDER 24 HRS. Months <u>05</u> Days <u>05</u> Hours <u>05</u> Min. <u>05</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland, Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Fleischman</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth--- Geiss</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Hospital Records Springfield State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolism</u> DUE TO (b) <u>Syphilitic Aortitis</u> DUE TO (c) <u>Hypertensive cardiovascular disease</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Chronic brain syndrome associated with central nervous system syphilis, meningoencephalitic with psychotic reaction.</u>						INTERVAL BETWEEN ONSET AND DEATH hours <u>more than 1 yr.</u> <u>more than 5 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic brain syndrome associated with central nervous system syphilis, meningoencephalitic with psychotic reaction.</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>		20c. TIME OF INJURY Month, Day, Year <u>Hour a. m. 19</u> <u>p. m. 19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>October 20 19 59</u> to <u>Nov. 4 19 59</u> , that I last saw the deceased alive on <u>Nov. 4 19 59</u> , and that death occurred at <u>12:25 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter Knopp</u> M.D.				ADDRESS (Street, city or town, state) <u>11-4-59</u> DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/7/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Schimunek</u>				ADDRESS <u>3331 Brehms Lane</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 6 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1921

NAME OF DECEASED		DATE OF DEATH	
MAYNARD		JAN 10 1921	
AGE		SEX	
34		M	
RACE		OCCUPATION	
W		C	
PLACE OF BIRTH		PLACE OF DEATH	
BALTIMORE		BALTIMORE	
MARRIED		CAUSE OF DEATH	
Y		DISEASE	
DATE OF MARRIAGE		PLACE OF BIRTH	
JAN 10 1917		BALTIMORE	
MOTHER'S NAME		FATHER'S NAME	
J. M. MARYNARD		J. M. MARYNARD	
MOTHER'S PLACE OF BIRTH		FATHER'S PLACE OF BIRTH	
BALTIMORE		BALTIMORE	
MOTHER'S DATE OF BIRTH		FATHER'S DATE OF BIRTH	
JAN 10 1887		JAN 10 1887	
MOTHER'S PLACE OF DEATH		FATHER'S PLACE OF DEATH	
BALTIMORE		BALTIMORE	
MOTHER'S DATE OF DEATH		FATHER'S DATE OF DEATH	
JAN 10 1917		JAN 10 1917	
MOTHER'S CAUSE OF DEATH		FATHER'S CAUSE OF DEATH	
DISEASE		DISEASE	
DATE OF MARRIAGE		PLACE OF BIRTH	
JAN 10 1917		BALTIMORE	
MOTHER'S NAME		FATHER'S NAME	
J. M. MARYNARD		J. M. MARYNARD	
MOTHER'S PLACE OF BIRTH		FATHER'S PLACE OF BIRTH	
BALTIMORE		BALTIMORE	
MOTHER'S DATE OF BIRTH		FATHER'S DATE OF BIRTH	
JAN 10 1887		JAN 10 1887	
MOTHER'S PLACE OF DEATH		FATHER'S PLACE OF DEATH	
BALTIMORE		BALTIMORE	
MOTHER'S DATE OF DEATH		FATHER'S DATE OF DEATH	
JAN 10 1917		JAN 10 1917	
MOTHER'S CAUSE OF DEATH		FATHER'S CAUSE OF DEATH	
DISEASE		DISEASE	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12422

## CERTIFICATE OF DEATH

Reg. Dist. No.

12408

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural (Manchester)</i>		c. LENGTH OF STAY IN 1b <i>10 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>LEVI</i> - J - Middle <i>Forrester</i> Last <i>Forrester</i>		4. DATE OF DEATH Month <i>Nov</i> Day <i>13</i> Year <i>1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-16-1889</i>
9. AGE (In years last birthday) <i>70</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired operator</i>		12. KIND OF BUSINESS OR INDUSTRY <i>Balto Transit</i>	
13. FATHER'S NAME <i>Philmore Forrester</i>		14. MOTHER'S MAIDEN NAME <i>Arabella Hendley</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-10-1488</i>	
17. INFORMANT <i>Jackson Forrester</i>		Address <i>Manchester Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Anteroseptal Heart Disease</i> DUE TO (c) <i>5 yrs</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June</i> , 19 <i>58</i> , to <i>Nov 13</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Nov 13</i> , 19 <i>59</i> , and that death occurred at <i>1:15 P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W H Foard</i>		ADDRESS (Street, city or town, state) <i>25 N Main St Manchester, Md</i>	
PHYSICIAN'S NAME (Type) <i>W H Foard M.D.</i>		DATE SIGNED <i>11-13-59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-16-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Baptist Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Manchester Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edw E Dutton</i>		ADDRESS <i>Hampstead Md</i>	
24a. REC'D BY REGISTRAR DATE <i>NOV 17 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



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## CERTIFICATE OF DEATH

12409

Reg. Dist. No.

12423

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural--Mt. Airy</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>J.</b> Last <b>FRANKLIN</b>		4. DATE OF DEATH Month <b>NOV.</b> Day <b>9,</b> Year <b>19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-25-1867</b>
9. AGE (In years last birthday) <b>91</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Nathan Franklin</b>		14. MOTHER'S MAIDEN NAME <b>Martha E. ??</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT Address <b>Mr. Olin Franklin, same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>444X</b> <b>General debility from age</b> DUE TO (b) <b>Hypertension, Arterio Sclerosis</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b> <b>3 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 23, 1959</b> , to <b>Nov 9, 1959</b> , that I last saw the deceased alive on <b>Oct 23, 1959</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. M. Van Boile</b> M.D.		DATE SIGNED <b>11-9-59</b>	
PHYSICIAN'S NAME (Type) <b>C. M. Van Boile</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11-12-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Taylorville</b>		22d. LOCATION (City, town, or county) (State) <b>Carroll Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b>		ADDRESS <b>Winfield, Md.</b>	
24a. REC'D BY REGISTRAR <b>NOV 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED <b>FRANKLIN J. FRANKLIN</b>		AGE <b>37</b>		SEX <b>Male</b>		RACE <b>White</b>		DATE OF DEATH <b>11-22-1967</b>		PLACE OF DEATH <b>Home</b>	
RESIDENCE <b>1101 N. 1st St. Baltimore, Md.</b>		OCCUPATION <b>None</b>		CAUSE OF DEATH <b>Myocardial Infarction</b>		MANNER OF DEATH <b>Natural</b>		CERTIFICATE NO. <b>11-22-1967</b>		REGISTRATION NO. <b>11-22-1967</b>	
DATE OF BIRTH <b>11-22-1930</b>		PLACE OF BIRTH <b>Baltimore, Md.</b>		EDUCATION <b>High School</b>		MARRIAGE <b>None</b>		PREVIOUS ILLNESS <b>None</b>		HISTORY OF PRESENT ILLNESS <b>None</b>	
DATE OF DEATH <b>11-22-1967</b>		PLACE OF DEATH <b>Home</b>		CAUSE OF DEATH <b>Myocardial Infarction</b>		MANNER OF DEATH <b>Natural</b>		CERTIFICATE NO. <b>11-22-1967</b>		REGISTRATION NO. <b>11-22-1967</b>	
DATE OF BIRTH <b>11-22-1930</b>		PLACE OF BIRTH <b>Baltimore, Md.</b>		EDUCATION <b>High School</b>		MARRIAGE <b>None</b>		PREVIOUS ILLNESS <b>None</b>		HISTORY OF PRESENT ILLNESS <b>None</b>	

12424

## CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead Rural</u>		c. LENGTH OF STAY IN 1b <u>40 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>DOSS - M - GARLAND</u>		<b>4. DATE OF DEATH</b> Month <u>Nov</u> Day <u>10</u> Year <u>1959</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Oct 30 - 1877</u>
<b>9. AGE</b> (In years last birthday) <u>82</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 MRS.</b> Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farmer</u>	<b>11. BIRTHPLACE</b> (State or foreign country) <u>North Carolina</u>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>Charles W Garland</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Sarah Garland</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>	
<b>16. SOCIAL SECURITY NO.</b> <u>no</u>		<b>17. INFORMANT</b> Address <u>Mrs John Sprinkle, Hampstead Md</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cremay Cerebral Prostate</u> 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Clinical studies Cerebral Vascular Disease</u>			<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>	<b>20f. (City or town)</b> (County) (State) <u>  </u>
<b>21. I certify that I attended the deceased from</b> <u>Oct 1</u> , 19 <u>57</u> , to <u>Nov 10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 10</u> , 19 <u>59</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.			
<b>ACTUAL SIGNATURE</b> <u>Joseph E Bush M.D.</u>		<b>ADDRESS</b> (Street, city or town, state) <u>Hampstead Maryland</u>	
<b>PHYSICIAN'S NAME</b> (Type) <u>Joseph E Bush M.D.</u>		<b>DATE SIGNED</b> <u>11-11-59</u>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>22b. DATE THEREOF</b> <u>11-13-59</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Hampstead</u>	<b>22d. LOCATION</b> (City, town, or county) (State) <u>Carroll Co Md</u>
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Edw E Tipton</u>		<b>ADDRESS</b> <u>Hampstead Md</u>	<b>24a. REC'D BY REGISTRAR</b> DATE <u>NOV 13 '59</u>
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur E. Kane</u>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12425

CERTIFICATE OF DEATH

12411

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. LENGTH OF STAY IN 1b <u>8 mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Longview Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CORA - I - GARRETT</u>		4. DATE OF DEATH Month Day Year <u>Nov 14 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Oct 28 - 1874</u>
9. AGE (In years lost birthday) <u>85</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Edward W Wine</u>	
14. MOTHER'S MAIDEN NAME <u>Louise Myers</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Paul R Garrett, Hampstead Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>72 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Aug 1</u> , 19 <u>55</u> , to <u>Nov 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 13</u> , 19 <u>59</u> , and that death occurred at <u>5:30 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jay C Bush</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead Md 11-14-59</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E Bush</u>		HAMPSTEAD MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-17-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Elvets</u>		22d. LOCATION (City, town, or county) (State) <u>Hannover Prussia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edna D. Dutton</u> ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 17 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur &amp; Thoma</u>	

US\$1



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12426

## CERTIFICATE OF DEATH

12412

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Fredrick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>1 yr. 15 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>Jefferson, Maryland</b> <b>10X-2</b>			
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>Nevin</b> Last <b>Gordon</b>				4. DATE OF DEATH Month <b>11</b> Day <b>14</b> Year <b>1959</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/11/74</b>		9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Sam Gordon</b>				14. MOTHER'S MAIDEN NAME <b>Lydia Ruse</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-24-1484</b>		17. INFORMANT <b>Springfield State Hospital records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <b>Congestive Heart Failure</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS assoc. with circulatory disturbance with cerebral arteriosclerosis with psychotic reaction.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>8/1/59</b> , 19____, to <b>11/14/59</b> , 19____, that I last saw the deceased alive on <b>11/14/59</b> , 19____, and that death occurred at <b>6:40 a.m.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Francesco Magro</b> M.D.				ADDRESS (Street, city or town, state) <b>14 Nov 1959</b> DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>Francesco Magro, M.D.</b>		SYKESVILLE, MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-17-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Frederick Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. BURIAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>NOV 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

12413

12427

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Finksburg</b> c. LENGTH OF STAY IN 1b <b>19</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Finksburg</b> d. STREET ADDRESS <b>Murray Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Chloe</b> Middle <b>C.</b> Last <b>Grafton</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>25</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 28, 1871</b>
9. AGE (In years last birthday) <b>88</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>15</b> Hours <b>15</b> Min. <b>15</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Forest Hill, Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Kean</b>		14. MOTHER'S MAIDEN NAME <b>Street DeVoe</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Harry E. Ward</b>		Address <b>Finksburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardio Vascular Disease</b> DUE TO (c) <b>15 mins.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 mins.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>57</b> , to <b>Nov. 25</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Nov. 18</b> , 19 <b>59</b> , and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>48 Main Street</b> DATE SIGNED <b>11-27-59</b>			
ACTUAL SIGNATURE <b>Martin E. Strobel</b>		M.D. <b>Reisterstown, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Martin E. Strobel M.D.</b>		<b>Reisterstown, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 28, 59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Old Brick Church Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Jarrettsville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>		ADDRESS <b>48 Main Street</b>	
24a. REC'D BY REGISTRAR <b>NOV 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1927

MADE IN U.S.A.  
JUNIOR WIAF

<p>NAME OF DECEASED</p>		<p>AGE</p>	
<p>SEX</p>		<p>RACE</p>	
<p>DATE OF BIRTH</p>		<p>DATE OF DEATH</p>	
<p>PLACE OF BIRTH</p>		<p>PLACE OF DEATH</p>	
<p>CAUSE OF DEATH</p>		<p>IMMEDIATE CAUSE OF DEATH</p>	
<p>DATE OF EXAMINATION</p>		<p>TIME OF EXAMINATION</p>	
<p>SIGNATURE OF PHYSICIAN</p>		<p>SIGNATURE OF REGISTRAR</p>	
<p>DATE OF SIGNATURE</p>		<p>TIME OF SIGNATURE</p>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12428

## CERTIFICATE OF DEATH

12414

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll County</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll County</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hampstead</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>Hampstead</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>/</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lillian</b> Middle <b>M.</b> Last <b>Gutridge</b>		4. DATE OF DEATH Month <b>November</b> Day <b>5</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 22, 1926</b>
9. AGE (In years last birthday) <b>32</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry E. Kohls</b>		14. MOTHER'S MAIDEN NAME <b>Catherine L. Prietz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Henry E. Kohls</b> Address <b>Hampstead, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency</b> <b>416X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Rheumatic Heart Disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Angina Pectoris 1/2 year</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 Minutes</b> <b>2 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/14/59</b> , 19 <b>59</b> , to <b>11/5</b> , 19 <b>59</b> that I last saw the deceased alive on <b>11/4/59</b> , 19 <b>59</b> , and the death occurred at <b>10:45 p.m.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>M. C. Porterfield</b>		ADDRESS (Street, city or town, state) <b>Hampstead, Md.</b> DATE SIGNED <b>11/7/59</b>	
PHYSICIAN'S NAME (Type) <b>M. C. Porterfield</b>		<b>Hampstead, Md.</b> <b>11/7/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11-9-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>3310 Taylor Ave</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. C. Cook, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 10 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12415

12405

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN 1b <u>49 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>60 East Main St.</u>		d. STREET ADDRESS <u>60 E. Main St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HENRY HIRSH HARBAUGH II</u>		4. DATE OF DEATH Month Day Year <u>November 18 19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 15, 1910</u>
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Motel operator &amp; owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Westminster, Md</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry H. Harbaugh III</u>		14. MOTHER'S MAIDEN NAME <u>Sally Fleagle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-69-9156</u>	
17. INFORMANT <u>Egon W. Harbaugh, Westminster Md.</u>		Address <u>Willis St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>35 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/18</u> , 19 <u>59</u> , to <u>11/18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/18</u> , 19 <u>59</u> , and that death occurred at <u>10:35</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James I. Marsh</u> M.D.		ADDRESS (Street, city or town, state) <u>1058 Main St Westminster Md</u>	
DATE SIGNED <u>11/19/59</u>			
PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/24/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Broders Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rural Westminster Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.E. Myers, Jr. Westminster Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>NOV 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Pinner</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		DATE OF BIRTH [Faint text]	
PLACE OF BIRTH [Faint text]		PLACE OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
MEDICAL HISTORY [Faint text]		PRESENT ILLNESS [Faint text]	
TIME OF DEATH [Faint text]		PLACE OF INTERMENT [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]	
DATE [Faint text]		TIME [Faint text]	

1

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH  
 BALTIMORE

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12429

## CERTIFICATE OF DEATH

12416

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>50 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CARRIE ESTELLE HAWKINS</u>		4. DATE OF DEATH Month Day Year <u>Nov. 13 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 6, 1884</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jesse S. Brandenburg</u>		14. MOTHER'S MAIDEN NAME <u>Florence Carroll</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Oscar Hawkins - Sykesville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis, arteriosclerosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerotic heart disease</u> DUE TO <u>Hypertension</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1955 to 13 Nov 1959</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1955</u> , 19____, to <u>13 Nov. 1959</u> , that I last saw the deceased alive on <u>13 Nov. 1959</u> , and that death occurred at <u>3:05 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.		DATE SIGNED <u>13 Nov 59</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>		<u>SYKESVILLE, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>11-16-59</u>	<u>Springfield</u>	<u>Sykesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Haight</u> ADDRESS <u>Sykesville, Md.</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
		<u>NOV 18 '59</u>	<u>Arthur S. Hanes</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12-3-33

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 12 1898		MEMPHIS, TENN.	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE	
CLOCK REPAIRER		HIGH SCHOOL		MARRIED		METHODIST		WHITE	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		HOURS OF DEATH	
HEART DISEASE		SUICIDE		HOME		DEC 3 1933		10:00 PM	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS ACCIDENT		PREVIOUS POISON	
NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. [Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE		TIME		PLACE		DATE		TIME	
DEC 3 1933		10:00 PM		HOME		DEC 3 1933		10:00 PM	

RECORDED

INDEXED

12430

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Barnell</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Barnell</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. LENGTH OF STAY IN 1b <u>25 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BIRDIE - HOFFACKER</u>		4. DATE OF DEATH Month <u>NOV</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>FF</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-1-1889</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George W Hoffacker</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Lundeos.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-07-1613</u>	
17. INFORMANT <u>Mrs Harvey Rhodes Westminster, MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>5 yr</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>48</u> , to <u>Nov 12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct</u> , 19 <u>59</u> and that death occurred at <u>2 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W H Foard</u> M.D. <u>25 N MAIN ST</u>		DATE SIGNED <u>11/13/59</u>	
PHYSICIAN'S NAME (Type) <u>W H Foard M.D.</u>		<u>MANCHESTER, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>11-15-59</u>	<u>Manchester</u>	<u>Barnell Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw A Tipton</u> ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 17 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur A. Evans</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







Carroll

YES ☐ NO ☒

Hours	Min.
-------	------

USA

Charlotte Lenthicium

Mrs. William Gist Jr. Finksburg, Md.

INTERVAL BETWEEN  
ONSET AND DEATH[illegible]

15

19. WAS AUTOPS

19. WAS AUTOPS PERFORMED?  
YES ☐ NO ☐

(State)

DATE SIGNED \_\_\_\_\_

mf

W. P. Atkinson

(State)

24b. REGISTRAR'S SIGNATURE

Arthur S. Kline

CERTIFICATE OF DEATH

1914

Blank form with horizontal lines for text entry.



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12419

12432

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>Maryland</u> <u>Baltimore</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> <u>3V01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>3625 Columbia Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Cyries</u> Middle <u>Dorothy</u> Last <u>Kellner</u>		4. DATE OF DEATH Month <u>November</u> Day <u>10</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-20-08</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>5</u>	11. IF UNDER 24 HRS. Hours <u>10</u> Min. <u>59</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Never Gainfully Emp.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Emmanuel Kellner</u> <u>Deceased</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Kellner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Springfield State Hospital Records</u>		Address <u>Springfield State Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Neoplasm in the Intestines.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ulcerative Colitis.</u> DUE TO (c) <u>Chronic Brain Syndrome associated with Convulsive Seizures</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated with Convulsive Seizures</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 7, 19 55</u> , to <u>November 10, 19 59</u> that I last saw the deceased alive on <u>November 10, 19 59</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ilse Kamm</u>		DATE SIGNED <u>November 10, 1959</u>	
PHYSICIAN'S NAME (Type) <u>Ilse Kamm, M.D.</u>		ADDRESS (Street, city or town, state) <u>Sykesville, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/12-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Adas Israel Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg</u>		24a. REC'D BY REGISTRAR <u>42179</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>		DATE <u>NOV 13 '59</u>	

CERTIFICATE OF DEATH

12432

1

NAME OF DECEASED: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF PHYSICIAN: [illegible]  
SIGNATURE OF WITNESSES: [illegible]  
SIGNATURE OF REGISTRAR: [illegible]

## CERTIFICATE OF DEATH

Reg. Dist. No.

12433

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Spencerville</b> 15x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>				d. STREET ADDRESS <b>Box 6, Batson Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle <b>Theodore</b> Last <b>Kelly</b>				4. DATE OF DEATH Month <b>11</b> Day <b>27</b> , Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-27-1890</b>		9. AGE (In years last birthday) yrs. <b>69</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Spencerville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nelson E. Kelly</b>				14. MOTHER'S MAIDEN NAME <b>Selena Taylor</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		INFORMANT <b>Eleanor Smith - Niece</b>		Address <b>Box 6, Batson Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident due to hypertensive</b> <b>443X</b> DUE TO <b>cardiovascular disease.</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Undiagnosed minimal pulmonary disease.</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 25, 1959</b> , to <b>Nov. 27, 1959</b> , that I last saw the deceased alive on <b>Nov. 27, 1959</b> , and that death occurred at <b>5:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b> DATE SIGNED <b>11-27-59</b> ACTUAL SIGNATURE <b>Edgars M. Maculans</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. Edgars M. Maculans, Supt. Henryton State Hospital, Henryton, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/30/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Round Oak Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Spencerville, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Sander</b>				ADDRESS <b>Rockville Md</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 30 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58



Carroll

Henington

Henington State Hospital

Box 6, Salem Road

General

Kelly

Male

6-27-1899

Helena E. Kelly

John Taylor

No

Box 6, Salem Rd.

Cardiovascular accident due to hypertensive  
cardiovascular disease.  
Undiagnosed minimal pulmonary disease.

Nov. 27

Nov. 27

Nov. 27

Nov. 27

Henington, Maryland

Dr. Eugene M. Woodman, M.D.

Henington State Hospital, Henington, Md.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

12422

Reg. Dist. No.

12435

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Rural) Sykesville, Maryland</u>		c. LENGTH OF STAY IN 1b <u>5yr. 2mo. 14da.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Baltimore</u>		3. NAME OF DECEASED (Type or print) First Middle Last <u>Benedict Thomas Krug</u>		4. DATE OF DEATH Month Day Year <u>11 12 1959</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-28-92</u>		9. AGE (In years last birthday) <u>67</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ferryman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Frederick Krug</u>		14. MOTHER'S MAIDEN NAME <u>Madelene Gast</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>	
16. SOCIAL SECURITY NO. <u>1918</u>		17. INFORMANT <u>Hospital Records</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Generalized arteriosclerosis</u> (c) <u>Generalized arteriosclerosis</u> PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mental deficiency, undifferentiated.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>more than 10 yrs.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Springfield State Hospital</u>		(County) <u>Baltimore</u>		(State) <u>Md.</u>		21. I certify that I attended the deceased from <u>Aug. 1955</u> , 19 <u>55</u> , to <u>11-12-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11-12-59</u> , 19 <u>59</u> , and that death occurred at <u>7:30</u> M., from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Walter Knopp</u>		PHYSICIAN'S NAME (Type) <u>Walter Knopp, M.D.</u>		ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u>		DATE SIGNED <u>Nov 17 '59</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 16, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	
22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u>		(State) <u>Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home</u>		ADDRESS <u>2112 Dundalk Ave.</u>		24a. REC'D BY REGISTRAR <u>Nov 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Knapp</u>		24c. DATE <u>Nov 17 '59</u>	

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12434

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		c. LENGTH OF STAY IN TB <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Charles A. Kohls</i>		4. DATE OF DEATH <i>November 10 1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 22, 1887</i>
9. AGE (In years last birthday) <i>72</i> yrs.		10. IF UNDER 1 YEAR: Months <i>72</i> Days <i>72</i> Hours <i>72</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Electrician</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Navy</i>	
11. BIRTHPLACE (State or foreign country) <i>md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Kohls</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Whittman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> <i>W.W. 1-11</i>		16. SOCIAL SECURITY NO. <i>yes</i>	
17. INFORMANT <i>Mrs. Minnie Kohls - Sykesville, md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ARTERIOULAR NEPHROSCLEROSIS, MALIGNANT</i> 441X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>HYPERTENSIVE CARDIOVASCULAR DISEASE</i> DUE TO (c) <i>ARTERIOSCLEROTIC HEART DISEASE</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs.</i> <i>10 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1949</i> , 19 <i>Nov. 10</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Nov. 9</i> , 19 <i>59</i> , and that death occurred at <i>4:15 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wm. H. Lawson, Jr.</i> M.D.		ADDRESS (Street, city or town, state) <i>Liberty Road at Eldersburg</i> DATE SIGNED <i>11/10/59</i>	
PHYSICIAN'S NAME (Type) <i>Wm. H. Lawson, Jr., M.D.</i>		<i>Sykesville-2, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11-12-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Springfield</i>	22d. LOCATION (City, town, or county) (State) <i>Sykesville, md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur A. Hight</i> ADDRESS <i>Sykesville, md.</i>		24a. REC'D BY REGISTRAR <i>NOV 18 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hight</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12423

12436

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY <u>Harroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster Rural</u>	
c. LENGTH OF STAY IN 1b <u>40 yrs</u>		d. STREET ADDRESS <u>Westminster</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>✓</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES - A - MAHANNA</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-25-1895</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u>	11. IF UNDER 24 HRS. Hours <u>10</u> Min. <u>0</u>
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		13. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>	
14. BIRTHPLACE (State or foreign country) <u>Maryland</u>		15. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
16. FATHER'S NAME <u>Charles E Mahanna</u>		17. MOTHER'S MAIDEN NAME <u>Ella Ward</u>	
18. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		19. SOCIAL SECURITY NO. <u>No</u>	
20. INFORMANT <u>Vernon Mahanna</u>		Address <u>Hampstead Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Thrombosis</u> (c) <u>Coronary Sclerosis</u> DUE TO cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>several</u> <u>hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W. Lewis Speicher</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>acting</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Nov 18-1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-21-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Leister</u>	22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw &amp; Dipton</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 20 '59</u>	
ADDRESS <u>Hampstead Md</u>		24b. REGISTRAR'S SIGNATURE <u>Carroll E. Kiser</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

1

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1923

NAME OF DECEASED: CHARLES B. WATKINS

AGE: 35

SEX: Male

RACE: White

DATE OF BIRTH: 1888

PLACE OF BIRTH: England

DATE OF DEATH: 1923

PLACE OF DEATH: Home

CAUSE OF DEATH: Heart Disease

DETAILS OF DEATH: Heart Disease

SIGNATURE OF EXAMINER: [Signature]

DATE: 1923

LOCATION: Baltimore

1



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

12424

Reg. Dist. No.

12437

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>1yr. 22 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
f. STREET ADDRESS <b>1008 McAleer Court</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Leon</b> Middle <b>Joseph</b> Last <b>McComas</b>		4. DATE OF DEATH Month <b>November</b> Day <b>19</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 17, 1909</b>
9. AGE (In years last birthday) <b>49</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Leon Joseph McComas</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Dewart</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>215-09-5359</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute peritonitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Septicemia caused by infected gangrenous feet</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute brain syndrome associated with drug or poison intoxication. Steroid medication &amp; periarteritis nodosa.</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 27, 1958</b> , to <b>November 19, 1959</b> , that I last saw the deceased alive on <b>November 19, 1959</b> , and that death occurred at <b>7:20 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Agustin del Campo</b> M.D. <b>Springfield State Hospital</b> <b>11/20/59</b> PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b> <b>Sykesville, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>11-24-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 23 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Christina L. Kruza</b>			

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12438

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Taneytown</b>				c. LENGTH OF STAY IN 1b <b>X</b> <b>Rural Taneytown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				/d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Luther</b> Middle <b>David</b> Last <b>Mehring</b>				4. DATE OF DEATH Month <b>November</b> Day <b>10</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 18, 1887</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Luther W. Mehring</b>		14. MOTHER'S MAIDEN NAME <b>Leah Reindollar</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <b>Dr. Percy Mehring, Phila., Pa.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Arterio Sclerosis</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 6, 1959</b> to <b>11-10-</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11-11-</b> , 19 <b>59</b> and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Union Bridge Md 11-12-59</b> DATE SIGNED							
ACTUAL SIGNATURE <b>J. N. Legg</b>				M.D. <b>Union Bridge Md 11-12-59</b>			
PHYSICIAN'S NAME (Type) <b>T. H. LE G G</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 13, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Taneytown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. O. Fuss &amp; Son</b> ADDRESS <b>Taneytown, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hays</b>	

1

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

CERTIFICATE OF DEATH

1923

County

Township

State

First Name

Last Name

Age

Sex

Color

Religion

25

June 1, 1898

White

Male

W.C.A.

Married

Third

Irish Catholic

English

Dr. Henry Smith, M.D.

Sanford, Maryland

Sanford, Maryland

Nov. 10, 1923

Sanford, Maryland

Dr. Henry Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 7 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12426

12439

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>4 yr. 8 mo. 27 day.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>5318 Maple Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Bessie</b> Middle <b>Melvin</b> Last <b>Melvin</b>		4. DATE OF DEATH Month <b>November</b> Day <b>22,</b> Year <b>19 59</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARITAL STATUS <b>Widowed</b> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/>	8. DATE OF BIRTH <b>5-12-81</b>	9. AGE (In years last birthday) yrs. <b>78</b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>18</b> Hours <b>15</b> Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John Hawes</b>			14. MOTHER'S MAIDEN NAME <b>Sarah Muse</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		INFORMANT Address <b>Springfield State Hospital Records</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>420.0</b> DUE TO Arteriosclerotic Heart Disease (decompensated) Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome associated with Circulatory Disturbance, with Cerebral Arteriosclerosis, with Psychotic Reaction.</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>February 6, 1955</b> , to <b>November 22, 1959</b> , that I last saw the deceased alive on <b>November 22, 1959</b> , and that death occurred at <b>9:25 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>November 22, 1959</b>						
ACTUAL SIGNATURE <b>Joseph Flores</b>		M.D. <b>November 22, 1959</b>				
PHYSICIAN'S NAME (Type) <b>Joseph Flores, M.D.</b>		<b>Springfield State Hospital, Sykesville, Md.</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/25/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm J. Pickner &amp; Sons - Balt</b> <b>17 Md</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 24 '59</b>		24b. REGISTRAR'S SIGNATURE <b>William J. Pickner</b>

12430

12430

12430

1

1



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12427
Item 18 Film 252 11-23-59 ams										12440
CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville (Rural)</b>			c. LENGTH OF STAY IN lb <b>11 m. 27 d.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			1011.2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>					d. STREET ADDRESS <b>227 W. Fifth Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Della</b> Middle <b>Henrietta</b> Last <b>Miss.</b>					4. DATE OF DEATH Month <b>November</b> Day <b>16,</b> Year <b>19 59</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 25, 1898</b>		9. AGE (In years last birthday) yrs. <b>61</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>- -</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>George Whipp</b>					14. MOTHER'S MAIDEN NAME <b>Annie Howard</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>219-20-0518</b>		INFORMANT <b>Springfield State Hospital Record</b>					Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Rupture of left ventricle myocardium</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial infarction</b> (c) <b>Coronary arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, catatonic type</b> <b>Organic psychosis?</b>										INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Minutes</b> <b>Years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>November 19, 1958</b> , to <b>November 16, 1959</b> , that I last saw the deceased alive on <b>November 16, 1959</b> , and that death occurred at <b>8:10 A.M.</b> from the causes and on the date stated above.										
ACTUAL SIGNATURE <b>Konstantin Weber</b>			ADDRESS (Street, city or town, state) <b>Oak Street</b>				DATE SIGNED <b>11/16/59</b>			
PHYSICIAN'S NAME (Type) <b>Konstantin Weber, M. D.</b>			Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-18-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rocky Springs Cemetery</b>			22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Bailey Jr.</b>				ADDRESS <b>Frederick, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE NOV 18 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

CERTIFICATE OF DEATH

1940

General

Married

Residence

Place of Birth

Age

Sex

Place of Death

Date of Death

Time

Cause

Manner

Place

Time

Signature

Date

Place

Time

Signature

Signature

Signature

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

12428

12441

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>henryton</b>		c. LENGTH OF STAY IN lb <b>98 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>henryton State Hospital</b>		d. STREET ADDRESS <b>666 Sarah Ann Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Macie</b> Middle <b>bernice</b> Last <b>Moon</b>		4. DATE OF DEATH Month <b>November</b> Day <b>13</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-27-1932</b>
9. AGE (In years last birthday) <b>26</b> yrs.		IF UNDER 1 YEAR Months <b>26</b> Days <b>26</b> Hours <b>26</b> Min.	IF UNDER 24 HRS. Months <b>26</b> Days <b>26</b> Hours <b>26</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Okay Moon</b>		14. MOTHER'S MAIDEN NAME <b>Emma Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> If yes, give war or dates of service		16. SOCIAL SECURITY NO. <b>218-28-6214</b>	
INFORMANT <b>Macie B. Moon - Patient</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Vascular Insufficiency</b> DUE TO <b>Far Advanced Bilateral Cavitory</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Pulmonary Tuberculosis</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 7, 19 59</b> to <b>November 13, 19 59</b> that I last saw the deceased alive on <b>November 13, 19 59</b> , and that death occurred at <b>8:10 A.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edgars M. Maculans</b>		ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Edgars M. Maculans, Supt. Henryton State Hospital, Henryton, Md.</b>		DATE <b>11-13-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>11.19.59</b>		22b. DATE THEREOF <b>11.19.59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. of M. Anthony Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Newell</b>		24a. REG. BY REGISTRAR <b>NOV 23 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>		DATE	

1

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

# CERTIFICATE OF DEATH

Married

25 days

Married

666 Grand and Street

Married

November 15

Married

12-25-1922

Married

Married

Married

Married

Married

12-25-1922

Married

Married

Married

November 15

Married

November 15

Married

Married

1  
TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12442

## CERTIFICATE OF DEATH

12429

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HERMAN</b> Middle <b>RUNGE</b> Last <b>RUNGE</b>		4. DATE OF DEATH Month <b>November</b> Day <b>19</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 23, 1875</b>
9. AGE (In years lost birthday) yrs. <b>83</b>		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>01</b> Hours <b>4</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Salesman</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alfred Runge</b>		14. MOTHER'S MAIDEN NAME <b>Beatha (last name unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Records, Springfield State Hospital</b>		Address <b>Records, Springfield State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 25, 1957</b> to <b>November 19, 1959</b> , that I last saw the deceased alive on <b>November 19, 1959</b> , and that death occurred at <b>2:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>11-19-59</b>			
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D.		PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M. D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 23, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cent.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Moran</b>		24a. REC'D BY REGISTRAR <b>NOV 24 1959</b>	
ADDRESS <b>3000 E. Baltimore Street</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Flann</b>	

CERTIFICATE OF DEATH

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12443

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>1 month</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS <b>1315 Valley Street</b>				3V01-4			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>James</b> Last <b>Ryan</b>				4. DATE OF DEATH Month <b>November</b> Day <b>3</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 2, 1867</b>	
9. AGE (In years lost birthday) <b>92</b> yrs.		10. IF UNDER 1 YEAR Months <b>9</b> Days <b>2</b> Hours <b>15</b> Min.		11. IF UNDER 24 HRS. Months <b>9</b> Days <b>2</b> Hours <b>15</b> Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>String conductor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Frank J. Ryan</b>				14. MOTHER'S MAIDEN NAME <b>- Braden</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>-</b>			
INFORMANT <b>Springfield Hospital Records</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>C.B.S.assoc. with senile brain disease with psychotic reaction.</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S.assoc. with senile brain disease with psychotic reaction.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>October 2, 1959</b> to <b>November 3, 1959</b> , that I last saw the deceased alive on <b>November 2, 1959</b> , and that death occurred at <b>5:15 AM</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>11/3/59</b>							
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D. <b>Springfield State Hospital</b> <b>11/3/59</b>							
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b> <b>Sykesville, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>11-6-59</b> 22b. DATE THEREOF <b>11-6-59</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b> 22d. LOCATION (City, town, or county) <b>Balto Md</b> (State)							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Kuck</b> ADDRESS <b>5305 Harford Rd</b> 24a. REC'D BY REGISTRAR DATE <b>NOV 5 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>							

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

# CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>James J. Smith</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>January 1, 1900</u></p>		<p>4. Date of death: <u>November 1, 1950</u></p>	
<p>5. Place of birth: <u>St. Louis, Mo.</u></p>		<p>6. Place of death: <u>St. Louis, Mo.</u></p>	
<p>7. Cause of death: <u>Heart disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>November 1, 1950</u></p>		<p>12. Office of registration: <u>St. Louis, Mo.</u></p>	

12444

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>5 mos. 28 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Katherine</b> Middle <b>O'Connor</b> Last <b>Rytina</b>		4. DATE OF DEATH Month <b>November</b> Day <b>12</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 24, 1880</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min.	11. IF UNDER 24 HRS. Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Roger O'Connor</b>		14. MOTHER'S MAIDEN NAME <b>Ann Flynn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>	
INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with senile brain disease with psychotic reaction.</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Years</b> <b>Years</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 14, 1959</b> , to <b>November 12, 1959</b> , that I last saw the deceased alive on <b>November 11, 1959</b> , and that death occurred at <b>5:35 AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>11/12/59</b>			
ACTUAL SIGNATURE <b>Agustini del Campo</b>		M.D. <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/16/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CATHEDRAL</b>		22d. LOCATION (City, town, or county) (State) <b>FREDERICK RD MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suppel Bros</b>		ADDRESS <b>7110 BELAIR RD</b>	
24a. REC'D BY REGISTRAR DATE <b>NOV 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>William E. Hanna</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban poppers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12432
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>			c. LENGTH OF STAY IN 1b <b>5 mos. 17 das.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 2, Maryland</b> <b>3V01-4</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>					d. STREET ADDRESS <b>24 E. Preston Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Evelyn</b>		Middle <b>Blanche</b>		Last <b>Schreck</b>		4. DATE OF DEATH Month <b>November</b> Day <b>24</b> , Year <b>19 59</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-28-22</b>		9. AGE (In years last birthday) <b>36</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Book Binder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Robert Schreck</b>					14. MOTHER'S MAIDEN NAME <b>Agnes Miller</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>-</b>		17. INFORMANT <b>Springfield State Hospital Records</b>		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia due to occlusion of the trachea by a</b> <b>921.7</b> <b>DUETO piece of meat.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic Reaction, Paranoid Type</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Aspirated meat</b>								
20c. TIME OF INJURY Month, Day, Year <b>12:30 a.m. 11-24-59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>SS Hospital</b>		20f. (City or town) <b>Sykesville</b>		20g. (County) <b>Carroll</b>		
								20h. (State) <b>Md.</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <b>James T. Marsh</b>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <b>11-24-59</b>
EXAMINER'S NAME (Type) <b>James T. Marsh, M.D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/27/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>			22d. LOCATION (City, town, or county) <b>Parkville, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home</b>					ADDRESS <b>4210 Belair Road.</b>		24a. REC'D BY REGISTRAR <b>DATE NOV 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12446

## CERTIFICATE OF DEATH

12433

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>30yrs. 8mos. 20days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>1307 Clarkson St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Schwarz</b> Last <b>Schwarz</b>		4. DATE OF DEATH Month <b>November</b> Day <b>17</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 10, 1882</b>
9. AGE (In years lost birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Leopold Schwarz</b>		14. MOTHER'S MAIDEN NAME <b>Carrie Schauman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Congestive heart failure</b> DUE TO (c) <b>Arteriosclerotic heart disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Epilepsy with mental deficiency</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 11, 1958</b> to <b>Nov. 17, 1959</b> , that I last saw the deceased alive on <b>November 17, 1959</b> , and that death occurred at <b>9:20A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Francesco Magro</b> M.D.		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>11/17/59</b>	
PHYSICIAN'S NAME (Type) <b>Francesco Magro, M.D.</b>		<b>Sykesville, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/20/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		22d. LOCATION (City, town, or county) (State) <b>Friedrich Ave. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Krause Funeral Home</b>		ADDRESS <b>1216 S Charles St</b>	
24a. REC'D BY REGISTRAR <b>NOV 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## Reg. Dist. No.

## MEDICAL CERTIFICATION

VS A15 (4)  
15M 9/58

NEWLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1901

1. Name of deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of death: *Jan 15 1901*

5. Place of death: *Home*

6. Cause of death: *Heart Disease*

7. Signature of physician: *J. H. Smith*

8. Signature of registrar: *W. B. Jones*

9. Date of registration: *Jan 16 1901*

10. Place of registration: *City of Newland*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 12 Film G253 12-7-59 et

12448

CERTIFICATE OF DEATH

12435

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>11yr.6mo.21da.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Big Pool</b> d. STREET ADDRESS <b>21X-2</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Ora</b> Middle <b>Sites</b> Last <b>Sites</b>		4. DATE OF DEATH Month <b>November</b> Day <b>29,</b> Year <b>1959</b>							
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 28 1887</b> <b>Unknown</b>	9. AGE (In years last birthday) <b>72</b> yrs.	10. IF UNDER 1 YEAR Months <b>72</b>	11. IF UNDER 24 HRS. Days <b>72</b>	12. IF UNDER 24 HRS. Hours <b>72</b>	13. IF UNDER 24 HRS. Min. <b>72</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming Day Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>		11. BIRTHPLACE (State or foreign country) <b>Unknown Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>Unknown U.S.A.</b>			
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown -</b>		16. SOCIAL SECURITY NO. <b>7-0-38</b>		17. INFORMANT <b>SPRINGFIELD HOSPITAL RECORDS</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far advanced pulmonary tuberculosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>002X</b> (c) <b>Senile psychosis, depressed phase.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 25</b> , 19 <b>55</b> , to <b>November 29</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>November 29</b> , 19 <b>59</b> , and that death occurred at <b>8:20 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>11/29/59</b> ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D. <b>Springfield State Hospital</b> PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b> <b>Sykesville, Maryland</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-3-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Public Family Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Onego, W. Va.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur A. Knight Sykesville, Md.</b>				24a. REC'D BY REGISTRAR <b>DEC 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

1846

CERTIFICATE OF DEATH

1846

1

1846

1846

1846

1

1846

1846



12449

Items 2, 11, 12 Film 6253 12-7-59 et

CERTIFICATE OF DEATH

12436

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>md</b> b. COUNTY <b>CARRROLL ?</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>4 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>015 Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JOHN</b> First <b>SMITH</b> Last				4. DATE OF DEATH <b>11</b> Month <b>28</b> Day <b>1959</b> Year			
5. SEX <b>M</b>	6. COLOR OR RACE <b>WH</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>UNKNOWN</b>	9. AGE (In years last birthday) <b>58</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>UNKNOWN</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>UNKNOWN</b> INFORMANT <b>Hospital Records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> <b>ARTERIOSCLEROTIC HEART DISEASE.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>420.0</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1) FAR ADVANCED BILATERAL PULMONARY TUBERCULOSIS. ACTIVE.</b> <b>2) SCHIZOPHRENIA</b> <b>002X</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>SEPT 11-27</b> , 19 <b>55</b> to <b>11-27</b> , 19 <b>59</b> that I last saw the deceased alive on <b>11-27</b> , 19 <b>59</b> , and that death occurred at <b>7:25 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Julian Radzykenycz</b> M.D.				ADDRESS (Street, city or town, state) <b>Olyphanville, Md.</b> DATE SIGNED <b>11/28/59</b>			
PHYSICIAN'S NAME (Type) <b>JULIAN RADZYKENYCH MD</b>				<b>SYKESVILLE, MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-1-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur H. Knight</b> ADDRESS <b>Olyphanville, Md.</b>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <b>DEC 2 '59</b>							



1949  
CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH

1949

Blank form with horizontal lines for text entry.



U.S. GOVERNMENT PRINTING OFFICE: 1962



12451

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>8 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>1666 Northbourne Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Nellie</b> Middle <b>Pearce</b> Last <b>Stafford</b>		4. DATE OF DEATH Month <b>November</b> Day <b>24</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1880 February 6,</b>
9. AGE (In years last birthday) <b>79 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleslady</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Israel Pearce</b>		14. MOTHER'S MAIDEN NAME <b>Mary Mossholder</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-03-3102</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Years</b> <b>Years.</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 26,</b> 19 <b>59</b> , to <b>November 24, 1959</b> , that I last saw the deceased alive on <b>November 24,</b> 19 <b>59</b> , and that death occurred at <b>11:15 AM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Francesco Magro M.D.</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Francesco Magro, M.D.</b>		DATE SIGNED <b>11/24/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11'27'59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Avenue</b>	
24a. REC'D BY REGISTRAR DATE <b>NOV 27 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. Howard</b>	

1

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

CENTRIFUGAL OF DEATH

1900

1888

Howard H. Hubbard #107 Wilkens Avenue  
Burial 11/27/99 Mt. Olive Cemetery, Baltimore, Maryland



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12452

12439

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Taneytown</b>		c. LENGTH OF STAY IN lb <b>2 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peterson Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Amanda</b> Middle <b>L.</b> Last <b>Stahley</b>		4. DATE OF DEATH Month <b>November</b> Day <b>27</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 2, 1873</b>
9. AGE (In years last birthday) <b>86 yrs.</b>		10. IF UNDER 1 YEAR Months <b>86</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joel Bollinger</b>		14. MOTHER'S MAIDEN NAME <b>Mary Bollinger</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
INFORMANT <b>Mr. James P. Stahley</b>		Address <b>Taneytown, Md. RD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis and Myocardial Degeneration.</b> 420.0 DUE TO (b) <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>Permanently Arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>5 yrs.</b> <b>10 yrs.</b> <b>10 yrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>10/11</b> , 19 <b>44</b> to <b>11/27</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11/20</b> , 19 <b>59</b> , and that death occurred at <b>5 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R. S. McVaugh</b>		ADDRESS (Street, city or town, state) <b>Taneytown, Md.</b>	
PHYSICIAN'S NAME (Type) <b>R. S. McVaugh</b>		DATE SIGNED <b>11/27/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov 29, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Reformed Church</b>	22d. LOCATION (City, town, or county) (State) <b>Taneytown Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Merwyn C. Luss</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 1 '59</b>	
ADDRESS <b>Taneytown Md</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kane</b>	

1942

11

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

WITNESSES

SIGNATURE OF DECEASED

SIGNATURE OF WITNESSES

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

12440

12453

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>1yr 11m 15d</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield St. Hospital</b>		d. STREET ADDRESS <b>722 Northern Parkway</b>	
3. NAME OF DECEASED (Type or print) <b>Bertha Taylor</b>		4. DATE OF DEATH <b>11 15 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-16-81</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George W. Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Isabella Ann Sisco</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Springfield St. Hosp.</b>		Address <b>Sykesville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>521X</b> IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Pulmonary Abscess</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>CBS ass. with disturbance of metabolism, growth or nutrition with senile brain disease, with psychotic reaction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>one week</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-27</b> , 19 <b>57</b> , to <b>11-15</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11-15</b> , 19 <b>59</b> , and that death occurred at <b>8:45A</b> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Dr. Joseph Flores</b>		M.D. <b>November 15, 1959</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/18/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons, Inc.</b>		ADDRESS <b>1900 Eutaw Place</b>	
24a. REC'D BY REGISTRAR <b>NOV 18 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MARTIN LUTHER KING, JR.

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1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>		c. LENGTH OF STAY IN lb <b>14 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>		d. STREET ADDRESS <b>Spencerville</b> 15x-2	
3. NAME OF DECEASED (Type or print) First <b>Jackson</b> Middle <b>Thomas</b> Last <b>Thomas</b>		4. DATE OF DEATH Month <b>November</b> Day <b>13</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-10-1916</b>
9. AGE (In years last birthday) yrs. <b>43</b>		10. IF UNDER 1 YEAR Months <b>43</b> Days <b>13</b> Hours <b>19</b> Min.	11. IF UNDER 24 HRS. Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction worker</b>	
11. BIRTHPLACE (State or foreign country) <b>Kemington, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George E. Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Mary Sayles</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Jackson Thomas - Patient</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Sufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cirrhosis of liver &amp; Pulmonary tbc. with Pleurisy</b> (c) <b>Pleurisy</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>October 30, 1959</b> to <b>November 13, 1959</b> , that I last saw the deceased alive on <b>November 13, 1959</b> , and that death occurred at <b>6:15 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edgars M. Maculans</b> M.D.		ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b> DATE SIGNED <b>11-13-59</b>	
PHYSICIAN'S NAME (Type) <b>Edgars M. Maculans, Supt.</b>		<b>Henryton State Hospital, Henryton, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/15/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. James Baptist</b>	22d. LOCATION (City, town, or county) (State) <b>Bealeton, Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Sweeney</b>		24a. REC'D BY REGISTRAR <b>NOV 18 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur E. Knecht</b>

Page 4

death. Pages 1 and 2 should be filled with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

STATE OF MARYLAND

1895

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## CERTIFICATE OF DEATH

Reg. Dist. No.

12442

12455

1. PLACE OF DEATH a. COUNTY <b>Carroll County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN lb <b>1 year 6 mo.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Baltimore 5, Maryland</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>745 N. Patterson Pk. Ave.</b> d. STREET ADDRESS <b>745 N. Patterson Pk. Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Michael Trawinski</b>				4. DATE OF DEATH Month Day Year <b>11-22-59</b> <b>19</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-31-70</b>	
9. AGE (In years lost birthday) yrs. <b>89</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>11-22-59</b>		11. IF UNDER 24 HRS. Months Days Hours Min. <b>11-22-59</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labore r</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>nOne</b>			
11. BIRTHPLACE (State or foreign country) <b>Poland</b>				12. CITIZEN OF WHAT COUNTRY? <b>Naturalized</b>			
13. FATHER'S NAME <b>George Trawinski</b>				14. MOTHER'S MAIDEN NAME <b>None given</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>212-14-0807</b>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far advanced bilateral pulmonary Tuberculosis</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Arteriosclerosis Heart Disease</b> DUE TO <b>Years</b> (c) <b>Chronic Brain Syndrome, associated with senility</b>				18. INTERVAL BETWEEN ONSET AND DEATH <b>1 year 6 mo.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome, associated with senility</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>11-21-59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-21-58</b> , 19 <b>58</b> , to <b>11-22</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11-21</b> , 19 <b>59</b> , and that death occurred at <b>1:05a</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Gravene</b> M.D.				PHYSICIAN'S NAME (Type) <b>M. D. Francesco Magro M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-24-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Springfield Hosp. Sykes. Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank Cvach &amp; Son,</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 23 '59</b>			
ADDRESS <b>900 N. Chester St. Balto.5</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

1

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

CERTIFICATE OF DEATH

1912



Parson's County

1. Name of deceased: [illegible]

2. Date of death: [illegible]

3. Age: [illegible]

4. Sex: [illegible]

5. Cause of death: [illegible]

6. Place of death: [illegible]

7. Name of physician: [illegible]

8. Name of informant: [illegible]

9. Signature of informant: [illegible]

10. Name of registrar: [illegible]

11. Name of registrar: [illegible]

12. Name of registrar: [illegible]

13. Name of registrar: [illegible]

14. Name of registrar: [illegible]

15. Name of registrar: [illegible]

16. Name of registrar: [illegible]

17. Name of registrar: [illegible]

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VS A15 (4)  
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G252 11-23-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

12443

12456

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN lb <b>3Y 10M 1D</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>5800 Walter Av., Baltimore 6, Md.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Emma Bertha Stahn Von Bussenius</b> First Middle Last 4. DATE OF DEATH <b>Nov. 14 19 59</b> Month Day Year		5. SEX <b>F</b> 6. COLOR OR RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>3.13.80</b> 9. AGE (In years last birthday) <b>79</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>dressmaker</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b> 11. BIRTHPLACE (State or foreign country) <b>Germany</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A., naturalized</b>		13. FATHER'S NAME <b>unknown</b> 14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <b>None</b> INFORMANT Address <b>Springfield State Hospital</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Congestive Heart Failure</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome Associated with Arteriosclerosis</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>11-13-59</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>11-13-59</b> to <b>11-14-59</b> , that I last saw the deceased alive on <b>11-13-59</b> , and that death occurred at <b>12:55 A.M.</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>11.14.59</b> ACTUAL SIGNATURE <b>Joseph Flores</b> M.D. <b>Sykesville, Md.</b> PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>11-17-1959</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore</b> 22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Lorahn Funeral Home</b> ADDRESS <b>744 Belair Rd</b> 24a. REC'D BY REGISTRAR DATE <b>NOV 17 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

# CERTIFICATE OF DEATH

1945

WHO died at residence of decedent

at residence of decedent

born at residence of decedent

born at residence of decedent

at residence of decedent

at residence of decedent

at residence of decedent

at residence of decedent

at residence of decedent

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12444

12457

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Taneytown</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edna</b> Middle <b>Jane</b> Last <b>Wantz</b>		4. DATE OF DEATH Month <b>November</b> Day <b>13</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 1, 1886</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Carbaugh</b>		14. MOTHER'S MAIDEN NAME <b>Hannah Wantz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mr. Solomon E. Wantz, Taneytown, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Nervous Shock</b> (c) <b>sudden</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 7, 1958</b> to <b>Nov 8, 1959</b> , that I last saw the deceased alive on <b>Nov 8, 1959</b> , and that death occurred at <b>9:15 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>T. H. Legg</b> M.D.		ADDRESS (Street, city or town, state) <b>Union Bridge Md</b> DATE SIGNED <b>11-15-59</b>	
PHYSICIAN'S NAME (Type) <b>T.H.Legg, M.D.</b>		<b>Union Bridge, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/16/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baust Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Tyrone, Carroll, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.O. Fuss &amp; Son</b> ADDRESS <b>Taneytown, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 18 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

# CERTIFICATE OF DEATH

1943

County

Township

City

State

County

Post Office

Sex

Age

Color

Rank

Line

Page

Mar.

Apr.

May

June

July

Aug.

Sept.

Oct.

Nov.

Dec.

Name of Deceased

Age

Sex

Signature of Registrar

Witnesses

Union Address

Home Address

Signature of Registrar

Signature of Registrar

Signature of Registrar

Signature of Registrar

Signature of Registrar



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12458

## CERTIFICATE OF DEATH

12445

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Henryton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Henryton State Hospital</u>		d. STREET ADDRESS <u>610 Jasper Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Dorothy</u> Middle <u></u> Last <u>Waters</u>		4. DATE OF DEATH Month <u>November</u> Day <u>1</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 14, 1924</u>
9. AGE (In years last birthday) <u>35</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Waters</u>		14. MOTHER'S MAIDEN NAME <u>Ella Hughes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-10-1403</u> INFORMANT <u>Dorothy Water - Patient</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Far advanced bilateral cavitory pulmonary</u> <u>002 x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Tuberculosis, right thoracoplasty, right upper lobe resection</u> (c) <u>Cardiovascular Insufficiency</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>October 29, 1958</u> , to <u>November 1, 1959</u> , that I last saw the deceased alive on <u>November 1, 1959</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edgars M. Maculans</u> M.D.		ADDRESS (Street, city or town, state) <u>Henryton State Hospital</u> DATE SIGNED <u>11-1-59</u>	
PHYSICIAN'S NAME (Type) <u>Edgars M. Maculans, M.D.</u>		<u>Henryton, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>11/4/59</u>	22b. DATE THEREOF <u>11/4/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. AUBURN CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO.</u> <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Chatman</u> ADDRESS <u>1704 M. St. Baltimore</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 4 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove caplan papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

12423

1

12459

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>			c. LENGTH OF STAY IN 1b <b>25yrs. 8mos. 16days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
4. DATE OF DEATH Month <b>November</b> Day <b>23</b> Year <b>1959</b>			5. STREET ADDRESS <b>3600 Fairview Ave. 13013 Westwood Ave.</b>		
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Theresa</b> Last <b>Weber</b>			6. DATE OF BIRTH <b>June 2, 1876</b>		
5. SEX <b>Female</b>			6. COLOR OR RACE <b>White</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. AGE (In years lost birthday) <b>83</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sewing plant; housework</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Frank J. Weber</b>			14. MOTHER'S MAIDEN NAME <b>Annie Elliott</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>-</b>		
INFORMANT <b>Springfield Hospital Records</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause last. (b) <b>Congestive heart failure</b> DUE TO (c) <b>Arteriosclerotic cardiovascular disease</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Two weeks</b> <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Dementia praecox (schizophrenia)</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>March 7, 1955</b> to <b>November 23, 1959</b> that I last saw the deceased alive on <b>November 22, 1959</b> , and that death occurred at <b>1:40AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>11/23/59</b>					
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D.			PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>11/25/59</b>		
22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>			22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm J. Libbertson</b>			24a. REC'D BY REGISTRAR <b>NOV 24 '59</b>		
24b. REGISTRAR'S SIGNATURE <b>William S. Hume</b>					

TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

1934



*[Faint, mostly illegible text from the reverse side of the document, including fields for name, date, and location.]*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12460

## CERTIFICATE OF DEATH

12447

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural--Woodbine</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x rural--Woodbine</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>WELSH</b> Last		4. DATE OF DEATH Month <b>NOV.</b> Day <b>12,</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-5-1892</b>
9. AGE (In years last birthday) yrs. <b>67</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired watchman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Md. S.R.C.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Nimrod Welsh</b>		14. MOTHER'S MAIDEN NAME <b>Betty ??</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Mrs. Martha M. Welsh,</b>		Address <b>same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Grand Arterio Sclerosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>2 mths.</b> <b>8 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov 2</b> , 19 <b>59</b> , to <b>Nov 12</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Nov 12</b> , 19 <b>59</b> , and that death occurred on <b>Nov 12</b> , 19 <b>59</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>MORRELL N. MASTIN</b>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>MORRELL N. MASTIN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11-15-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Winfield Church of God</b>	22d. LOCATION (City, town, or county) (State) <b>Carroll Co., Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b>		ADDRESS <b>Winfield, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE NOV 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12448

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">12461</span> <div style="text-align: center; font-size: 1.2em;">Carroll</div> <div style="text-align: right; font-size: 0.8em;">MARYLAND</div>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <span style="font-size: 1.2em;">Maryland</span> b. COUNTY <span style="font-size: 1.2em;">Baltimore</span> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Catonsville</span> <span style="float: right; font-size: 0.8em;">0352-2</span>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Sykesville</span>		c. LENGTH OF STAY IN lb <span style="font-size: 1.2em;">16yrs. 10days</span>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <span style="font-size: 1.2em;">Springfield State Hospital</span>		d. STREET ADDRESS <span style="font-size: 1.2em;">401 Frederick Road</span>	
<b>3. NAME OF DECEASED</b> (Type or print) <div style="display: flex; justify-content: space-between;"> <span>First <span style="font-size: 1.2em;">Thomas</span></span> <span>Middle <span style="font-size: 1.2em;">F.</span></span> <span>Last <span style="font-size: 1.2em;">White</span></span> </div>		<b>4. DATE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <span>Month <span style="font-size: 1.2em;">November</span></span> <span>Day <span style="font-size: 1.2em;">9</span></span> <span>Year <span style="font-size: 1.2em;">19 59</span></span> </div>	
<b>5. SEX</b> <span style="font-size: 1.2em;">Male</span>	<b>6. COLOR OR RACE</b> <span style="font-size: 1.2em;">White</span>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">1900</span>
<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">59 yrs.</span>		<b>10. AGE</b> (In years last birthday) <div style="display: flex; justify-content: space-between;"> <span>IF UNDER 1 YEAR</span> <span>IF UNDER 24 HRS.</span> </div> <div style="display: flex; justify-content: space-between;"> <span>Months</span> <span>Days</span> <span>Hours</span> <span>Min.</span> </div>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Unknown</span>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">-</span>	
<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Unknown</span>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A.</span>	
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Unknown</span>		<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Unknown</span>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <span style="font-size: 1.2em;">No</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">-</span>	
<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Springfield Hospital Records.</span>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <span style="font-size: 1.2em;">Bronchopneumonia</span>  <div style="display: flex; justify-content: space-between;"> <span>491X</span> <span>DUE TO</span> </div> <div style="display: flex; justify-content: space-between;"> <span>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</span> <span>DUE TO</span> </div> </div>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <span style="font-size: 1.2em;">Psychosis with syphilitic meningoencephalitis. Fracture, left humerus.</span>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year <div style="display: flex; justify-content: space-between;"> <span>Hour <span style="font-size: 0.8em;">a. m.</span></span> <span><span style="font-size: 1.2em;">19</span></span> </div>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> . <b>Inspection</b> <input checked="" type="checkbox"/> . <b>Inquiry</b> <input checked="" type="checkbox"/> . and find that death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> . <b>Accident</b> <input type="checkbox"/> . <b>Suicide</b> <input type="checkbox"/> . <b>Homicide</b> <input type="checkbox"/> . <b>Undetermined cause</b> <input type="checkbox"/> .			
<b>ACTUAL SIGNATURE</b> <span style="font-size: 1.2em;">James T. Marsh</span>		<b>DATE SIGNED</b> <span style="font-size: 1.2em;">11/10/59</span>	
<b>EXAMINER'S NAME (Type)</b> <span style="font-size: 1.2em;">James T. Marsh, M.D.</span>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Buried</span>		<b>22b. DATE THEREOF</b> <span style="font-size: 1.2em;">Nov. 11, 1959</span>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">St. Mary's Cemetery</span>		<b>22d. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore Md.</span>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <span style="font-size: 1.2em;">Frank H. Marshall</span>		<b>24a. REC'D BY REGISTRAR</b> <span style="font-size: 1.2em;">NOV 13 '59</span>	
<b>24b. REGISTRAR'S SIGNATURE</b> <span style="font-size: 1.2em;">Arthur S. K...</span>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND DATE OF DEATH: <u>1918</u>		NAME OF DECEASED: <u>JOHN J. SMITH</u> SEX: <u>Male</u>	
AGE: <u>45</u>		OCCUPATION: <u>Engineer</u>	
PLACE OF BIRTH: <u>NEW YORK</u>		PLACE OF DEATH: <u>HOME</u>	
CAUSE OF DEATH: <u>Heart Disease</u>		MANNER OF DEATH: <u>Natural</u>	
TIME OF DEATH: <u>10:30 AM</u>		DATE OF EXAMINATION: <u>1918</u>	
SIGNATURE OF EXAMINER: <u>[Signature]</u>		SIGNATURE OF WITNESS: <u>[Signature]</u>	
CERTIFICATE NO. <u>12345</u>		COUNTY OF <u>BALTIMORE</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12449

12462

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>5 mo. - 19 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		d. STREET ADDRESS <b>2222 Washington Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>Cohen</b> Last <b>Witkowski</b>		4. DATE OF DEATH Month <b>11</b> Day <b>13</b> Year <b>1959</b>		5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/4/93</b>		9. AGE (In years lost birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>13</b> Hours <b>1959</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Max Cohen</b>		14. MOTHER'S MAIDEN NAME <b>Fanny Brodsky</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>288-05-7232</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bulbar Balsy</b> <b>356.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS associated with senile brain disease??</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/25/59</b> , 19____, to <b>11/13/59</b> , 19____, that I last saw the deceased alive on <b>11/13/59</b> , 19____, and that death occurred at <b>8:30p.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Springfield State Hosp. Sykesville, Md.</b>		DATE SIGNED <b>Nov 15 1959</b>		ACTUAL SIGNATURE <b>Francesco Magro</b>		M.D. <b>Francesco Magro, M.D.</b>		PHYSICIAN'S NAME (Type) <b>Sykesville, Maryland</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>NOV. 15, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>KING DAVID MEM. GARDEN FALLS CHURCH</b>		22d. LOCATION (City, town, or county) (State) <b>Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B DANZANSKY &amp; SONS - 3501-14th NW</b>		ADDRESS <b>3501-14th NW</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 18 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		24c. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		24d. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		24e. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		24f. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		24g. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		24h. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

CERTIFICATE OF DEATH

12462

Deceased Name: [Illegible]

Age: [Illegible] Sex: [Illegible]

Place of Birth: [Illegible]

Occupation: [Illegible]

Date of Death: [Illegible]

Place of Death: [Illegible]

Cause of Death: [Illegible]

Medical History: [Illegible]

Physician's Signature: [Illegible]

Medical Examiner's Signature: [Illegible]

This certificate is valid for [Illegible]

12/10

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12/10

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, end in any event within 72 hours after death.

VS. A15ME  
SM 7/59

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12450

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Westminster</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Westminster</b> d. STREET ADDRESS <b>Westminster</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GARY</b> Middle <b>BRIAN</b> Last <b>YINGLING</b>		4. DATE OF DEATH Month <b>November</b> Day <b>22</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 25 1959</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>Hanover, Penna</b>	
13. FATHER'S NAME <b>Arthur Yingling</b>		14. MOTHER'S MAIDEN NAME <b>Marie Stonesifer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		17. INFORMANT <b>Mr. Arthur Yingling as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>692.1</b> DUE TO <b>Cellulitis of Abdominal Wall.</b> Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Petty</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>11/23/59</b> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/25/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Valley</b>		22d. LOCATION (City, town, or country) (State) <b>Pleasant Valley Md.</b>	
23. FUNERAL DIRECTOR ADDRESS <b>Little Funeral Home Littlestown Pa</b>		24a. REC'D BY REGISTRAR <b>NOV 24 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

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MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
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FOR STATE  
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